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Accepted Manuscript

Facing violence – a global challenge

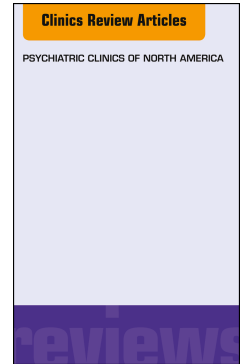
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Facing violence – a global challenge

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Key words:

violence, trauma, refugees, transcultural differences, posttraumatic stress, idioms of distress, prevention

Abstract

Violence has been shown lead to a global challenge leading to long lasting social, medical and mental health sequels. In this article we focus on massive social violence affecting groups such as war and civil war. Models developed in Western Europe and North America for understanding trauma related health problems and developing interventions cannot be sufficient to address this global health challenge. Culture is an important aspect of this challenge. Revisions of the APAs Diagnostical and Statistical Manual in DSM V, the discussion of dimensional approaches, new approaches in public mental and community health and closer interdisciplinary collaboration indicate a paradigm shift that reflects the complexity of issues. In displaced populations, the benefit of flight might be unbalanced by further problems due to forced migration. Social suffering and mental health problems related to violence as a global public health problem can only be tackled with a holistic approach that takes cultural, social, legal and economic determinants into account, and might also need a strong focus on human rights. Research that can give a reliable assessment of complex long term outcomes is still largely missing, and can be seen as a major and complex challenge for future research.

Key points:

- Sequels to violence can, due to their high prevalence and potentially severe long term impact, be seen globally as the potentially largest mental health challenge.
- Displacement can add additional challenges for victims and health care systems.
- An interdisciplinary approach integrating medical, and psychological but also legal and sociological aspects is required to address understanding, treating and preventing violence.
- A stronger focus on subjective, culture based and dimensional factors, as partly reflected in the new DSM V models, needs to be part of any intervention.

Introduction

Violence has been shown to lead to a global challenge resulting in long lasting social, medical and mental health sequelae. In this article we focus on massive social violence affecting groups, though it should be noted that especially sexual and domestic violence can have an equally severe impact on the life of individuals (^{1,2}). As Williams Nester has observed, the problem is substantial, as “269 wars involving 591 states broke out between 1945 and 1988 alone”, with an additional tendency of civil wars to be seen as a key challenge as “more than 85 percent of all wars between 1945 and 1976 were civil wars” (³), and numbers appear to be growing since then. While regions such as Syria or Iraq currently receive great public attention, with traumatic stress and suffering present in large parts of the populations, similar conditions apply for at least parts of many other countries either on a long-term base or during often reoccurring outbreaks of unrest, civil war and war.

Models developed in Western Europe and North America for understanding trauma related health problems and developing interventions cannot be sufficient to address this global health challenge. Culture is an important aspect of this challenge. Revisions of the APAs Diagnostical and Statistical Manual in DSM V (⁴), the discussion of dimensional approaches (⁵), new approaches in public mental and community health (⁶) and closer interdisciplinary collaboration indicate a paradigm shift that reflects the complexity of issues. For instance, in displaced populations, the benefit of flight might be unbalanced by further problems due to forced migration and experiences of exclusion and discrimination in the host country. To simplify the complex issue we will summarise key challenges and models for solutions by two main areas of concern.

Violence

TnQ: Please turn Box 1 from a Table into a Box.

	Violence is highly prevalent in a majority of countries or regions, risk of exposure is high especially if a longer observation period is used
	...can and frequently has long term impact on mental health including indirect trauma affecting the second and third generation and in helpers
	impact usually affects multiple levels including the individual, group and society
	long term sequels can be severe and partly treatment resistant
	is seen as a possible predictor of future violence

Box 1. Violence – Relevance for mental health, key points

Data from Refs ^{3, 7-14}

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An increasing host of data demonstrates long term impact not only on the individual, but also on social networks, economy and society (¹⁵) that must be seen as interfacing (see Box 1). Interconnections shape and are shaped by the kinds of violence encountered, physical and psychological injuries, increase in general morbidity, economic crises and the breakdown of societal structures, frequently accompanied by the brain drain of health care experts. These complexities in

combination with the persistent threat to personal and communal security create particular situations that cannot be compared to peace time conditions even in developing countries (^{15,16,17}). Additionally, there is usually a lack of resources which can be expected to further reduce support for patients with pre-conflict health and social problems, severe mental disorders and disabilities (¹⁸) and a general reconstruction of services besides development of specific services for trauma related disorders might be a major challenge (¹⁹).

Due to the often cumulative exposure to violence in contexts of conflict, particularly in settings of so-called "low" intensity war fare areas, it is difficult to measure, generalise or quantify stressors that might lead to or increase mental health problems, though it might be helpful to distinguish between isolated and repeated events or catastrophic environments (see Box 2).

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	Type I event (exposure): One time event
	Type II events (exposure): Repeated exposure or multiple events
	Type III events (exposure): Continuous or intermittent exposure over longer time period
	Type IV events (exposure): Longer exposure in childhood during psychological development

Box 2: Types of severe life events by time

Data from Wenzel T. Challenges in implementing the Istanbul Protocol. Göttingen2015 (in print).

Diagnostical considerations

Besides specific disorders that usually result only from extreme life events – especially Posttraumatic Stress Disorder (PTSD), - depression and other mood and anxiety disorders are also equally or even more common in populations exposed to violence (²¹⁻²³). Secondary complications like substance abuse or suicidal ideation in a prevalence rate that depends also on social and cultural factors (^{24,25}) are also common. Posttraumatic Stress Disorder is the trauma specific disorder which is best explored and has been demonstrated to have severe impact on the survivors life, and it has been shown that it to be highly prevalent in most affected regions even years after hostilities have ended though patterns of expression and coping might differ (²⁶). Less or nearly no data are available on adjustment disorders and the category describing the results of especially catastrophic events only included in ICD 10 ("Enduring *personality change* after catastrophic experience", F 62.0), This is partly related to a lack of translated and validated instruments for the last two disorders. Specific problems like trauma- and culture related psychosis (²⁷) or brain trauma (²⁸⁻³⁰) might constitute additional and underrated problems besides more common stress related disorders. Limitations of the PTSD concept on the background of culture have been the focus of continuous debate (³¹). The recent changes in DSM V do not address all controversial aspects raised (⁴) but can be seen as helpful as they integrate complex socio-psychological symptoms. They will require substantial adaptation of diagnostic and research tools including culture sensitive translation and revalidation also in regions with already limited resources.

Ethnographic research has highlighted that medicalising the experiences of trauma and, thereby, treating survivors of violence as patients precludes our understanding of how individuals, families and other social groups actually respond to violence, what their particular complex health and social care needs are, and through what capacities they contribute to the wider communities they belong to⁽³²⁾. This can best be achieved by conducting comparative qualitative or mixed method research. Particularly through participant observation, important insights may be gained into people's everyday lives and routine practices, their social relations, and behaviours, while qualitative interviews allow researchers to elicit complex narratives of symptom and illness experiences, explanatory models, local idioms of distress⁽³³⁾ as well as information related to health seeking behaviors and treatment experiences and possible resources to be mobilized for healing⁽³⁴⁾. These considerations have been taken up by DSM V through its "Cultural Formulation Interview" which, instead of providing a "list" of idioms of distress or syndromes of suffering, provides the structure of a qualitative interview to elicit these aspects (see Figure 1). This considerations have been taken up by DSM V that does not try to provide a "list" of idioms of distress or syndromes of suffering but provides the "Cultural Formulation Interview", that can be seen as a "semi"qualitative interview to elicit this aspects. It includes culture based "idioms of distress" and "cultural explanation or perceived illness"⁽³⁵⁾. Examples for such idioms are the West African "Kiyang-yang" as outlined by de Jong⁽³⁶⁾ or Ilaki and nakary as described by Pedersen et al.⁽³²⁾. Idioms and illness behavior can be expected to be of substantial clinical relevance, as they would influence factors such as help seeking and compliance⁽³⁷⁾.

<<AU: Please check mention of Figure 1 and move as needed. Mention was added by the Publisher.>>

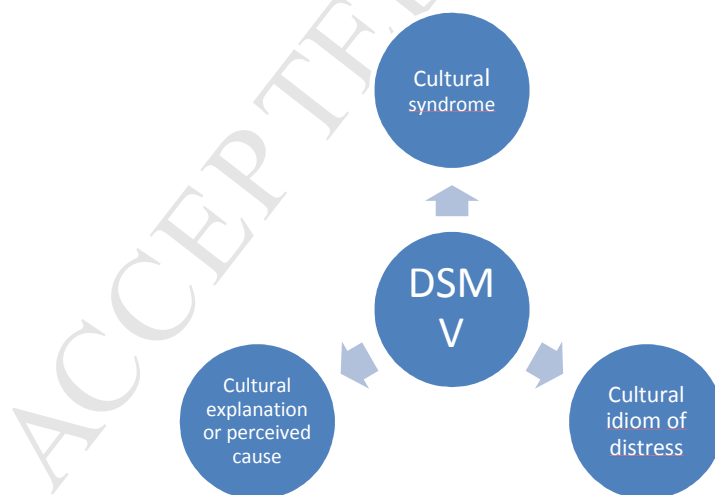


Figure 1: DSM and culture

While it is largely acknowledged that suffering itself is a universal human experience, the ways in which suffering is experienced and expressed differs depending on social and cultural determinants such as gender, age, ethnicity and religion as well as on economic situations and wider global

processes that impact on local worlds and people's lives. Moreover different forms of suffering can be distinguished. For instance, research in cultural anthropology has shown that the cultural meaning of suffering differs greatly between "routinized forms of suffering" that can be considered shared aspects of human conditions (e.g. chronic illness or death) or experiences of deprivation and exploitation and "suffering resulting from extreme conditions", such as survivorship of genocide ⁽³⁸⁾. The complexity of this reactions is illustrated by for example Coker ⁽³⁹⁾ who found, that southern Sudanese refugees in Cairo told stories of physical and social suffering which could be considered mourning for a lost cultural and physical normalcy as well as moral rage at their present circumstances. The author concludes that "illnesses were historicized and given meaning through the constant juxtaposition of time, place, and movement in narrative" (p. 27). Zarowsky ⁽⁴⁰⁾ contributes to the understating of emotion, suffering and trauma in different cultural and socio-political contexts by focusing on Ethiopian Somali returnees' narratives of emotion and suffering and comparing those with the literature on emotion in relation to trauma and the "refugee experience". According to her, emotional distress was about social rupture and injuries and not simply about private suffering. In fact, making a living under such harsh circumstances was a "recognition of the destruction of much of the fabric of the community at the same time as a refusal to vanish, a collective mourning of both private and collective losses at the same time as a deliberate creation of both history and the possibility of a future through the rhetorical (...) telling of the story of dispossession to each other, to their children, and to any outsiders who might be made to listen" (p. 202).

Interventions

Culturally and socially sensitive prevention strategies are of crucial importance due to the high prevalence and impact of sequels faced by individuals and groups exposed to armed conflict.

Primary prevention strategies usually focus on social, psychological and legal strategies. In contexts of mass violence during ethnic and political conflicts in countries like Rwanda or Syria, aetiology tends to reflect social and political factors. Safety and political stability might at first have to be supported by military action - if not caused by the same military -, but cannot be achieved by the same means, and a stable civil society is required to offer real safety as precondition for prevention and healing. As Worthington summarises "troops might effectively suppress military activities and reduce (but not usually eliminate) violence. Rarely can troops heal trauma, promote a re-establishment of the emotional bond between conflicting parties, and promote forgiveness and reconciliation, including the reduction or elimination of prejudices" ⁴¹.

Authors such as the psychiatrist and psychoanalyst Vamik Volkan have drawn attention to psychological factors that permit manipulation of large groups as prerequisite to such violence and have demonstrated that interventions based on group analytic models can contribute to early prevention. He described "chosen" traumata, - a symbolic representation of long distant earlier historical loss, like the catastrophe of the "Kosovo Polje" in Serb history - as a key instrument used in manipulation of group regression and preparation for violence ⁽⁴²⁾. Other authors have followed similar approaches to explain the genesis and possible interventions ⁽⁴³⁾.

The development of human rights standards and treaty systems such as the Geneva Conventions and the UN Convention against Torture can be seen as socio-legal contributions to primary prevention. The obligatory Istanbul Protocol ((IP), Manual on Effective Investigation and Documentation of Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment, ⁽⁴⁴⁾) supported by the UN and the World Medical Association assists medical doctors in the documentation of torture and inhuman and degrading treatment, contributing to prevention of torture practices, supporting criteria for protection in asylum and other procedures, and as secondary and tertiary prevention strategy helping victims to receive justice and redress ⁽⁴⁵⁾. Ethical standards including the IP demand a clear position and underline both the importance of health professionals and a close collaboration with legal professionals.

Secondary prevention. While Critical Incidence Stress Debriefing and Critical Incidence Management have over the last decade been established especially in the US as interventions that can in some cases prevent the development of stress related disorders ⁽⁴⁶⁾, data must still be seen as ambivalent, controversial or lacking especially in developing and post conflict countries (see also the new World Health organization guidelines for management of acute stress, PTSD, and bereavement ⁽⁴⁷⁾). Due to the complex interaction between concrete event related challenges, religious and cultural background, an uncritical transfer of models to local conditions should be seen as a dubious strategy. Existing cultural resources and strategies should be identified, evaluated and supported in place or as part of intervention packages ⁽⁴⁸⁾.

Treatment and tertiary prevention. Present treatment models are most commonly developed in Western Europe and North America reflecting at least in principle availability of necessary experts, i.e. especially psychiatrists and psychotherapists. The independent UK based NICE (National Institute for Clinical Excellence)) treatment guidelines on for example PTSD recommend Seroxate and especially Cognitive Behaviour Therapy as a standard in evidence based treatment (<https://www.nice.org.uk/guidance/cg26>, in review march 2015). It is good to keep in mind that trained psychotherapists or even psychiatrists are not available in most regions of the world, might not be accepted as care providers by clients due to mental health stigma and local health belief models, or are unaffordable if available at all. In case of massive and far spread violence, existing resources might not at all suffice even to cover the most urgent needs. Any intervention must be embedded in a more complex framework. The loss of local experts due to brain drain ⁽⁴⁹⁾, displacement and death cannot sustainably be balanced by third country humanitarian aid and treatment by foreign experts.

<<AU: Please check mention of Box 3 and move as needed. Mention was added by the Publisher.>>
An expert consortium headed by Hobfoll has proposed the following simple key needs listed in Box 3 below ⁽⁵⁰⁾:

1) A sense of safety,
2) calming,
3) a sense of self- and community efficacy,
4) connectedness,
5) hope.

Box 3: Five essential elements of immediate and mid-term mass trauma intervention

Data from Hobfoll SE, Watson P, Bell CC, et al. Five essential elements of immediate and mid-term mass trauma intervention: empirical evidence. *Psychiatry* 2007;70:283-315; discussion 6-69.

TnQ: Please turn Box 3 from a Table into a Box.

The new WHO guidelines provide a comprehensive framework that needs future exploration ⁽⁴⁷⁾.

Specific forms of Psychotherapy focusing on trauma as most common mental health problem that do not cover the complete range of clinical disorders or are based on short time intervention model have been successfully tested in crises regions as components for interventions. Basoglu has developed a focused approach of ultra-short treatment based on Cognitive Behaviour Therapy (CBT) ^(51,52) tested first in earth quake survivors. A recent study has reported positive results in a pilot study with former child soldiers using a culture adapted CBT approach ⁽⁵³⁾. Murray has developed and tested a “Common Elements Treatment Approach (CETA)” targeting mood or anxiety problems developed for use with lay counsellors in low- and middle-income countries (LMIC) ⁽⁵⁴⁾. Testimony therapy, an approach developed originally to face wide-spread torture in Latin American dictatorships, has influenced specialised approaches developed over the last decade, but has also been proposed if embedded in local culture ^(48,55,56). Narrative Exposure Therapy can be seen as a method well established in conflict zones ⁽⁵⁷⁾ and as in principle open to local culture. EMDR has been well established as evidence based intervention and first studies have been performed with refugee populations ⁽⁵⁸⁾, but most data are based on application by trained psychotherapists ⁽⁵⁹⁾. The recent Cochrane review for interventions torture survivors is sceptical as to this subgroup, summarising data for intervention as existing but still weak and limited to narrative therapy and CBT ⁽⁶⁰⁾, as in conclusions from refugee populations outlined below in Box 4. Criteria for medical evidence based interventions as in this model might be difficult to realise in post-conflict situations and might have to be adapted to complex interdisciplinary settings and outcome criteria ⁽⁶¹⁾.

<<AU: Please check mention of Box 4 and move as needed. Mention was added by the Publisher.>>

Limited training required
Training of available professionals or lay helpers
Low barrier
Culture sensitive
Resource oriented
Sustainable
Evidence based, monitoring and outcome evaluation

Box 4: Proposed general criteria for interventions in post-conflict areas and refugee populations

Data from Wenzel T. Challenges in implementing the Istanbul Protocol. Göttingen2015 (in print).

TnQ: Please turn Box 4 from a Table into a Box.

An increasing number of authors have as noted underlined the importance of existing resilience and healing models⁽⁶²⁾, and community based solutions are seen by most authors working in developing countries and post-conflict zones to be highly relevant as suffering is seen a social rather than purely individual experience⁽⁶³⁾. Examples include the family support project in Kosovo⁽⁶⁴⁾, while many centres in regions such as Ghaza have been pioneers in community oriented models, though again, most publications rather are descriptive and outcome studies are mostly missing. A general community orientation should in this context be differentiated from specific trauma related intervention community projects.

The concepts of curative or transitional justice can be seen as characteristic examples of community based approaches especially addressing the injustice gap perceived by the victims that might interfere also with psychological recovery. The use of “truth and reconciliation” committees like the South African Truth and Reconciliation Commission (SA TRC) or of a modified version of traditional court systems in Rwanda can be seen as important and culture sensitive models that might need further considerations and adaptation to achieve lasting positive results⁽⁶⁵⁾.

Decisions of international courts such as the European Court on Human Rights complement this local culture based models ([http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-144151#{%22itemid%22:\[%22001-144151%22\]}](http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-144151#{%22itemid%22:[%22001-144151%22]})) and the Interamerican Court (www.corteidh.or.cr/docs/casos/articulos/seriec_160_ing.pdf) and confirm the importance of psychological suffering in family members and indirect victims caused by complex factors like the impact of uncertain fate and lack of closure and urge rapid and complete action by authorities to avoid such suffering. Reparations and the right to rehabilitation include not only provision of treatment but also symbolic interventions like the recognition and social respect for victims.

Displacement as additional challenge

Both internal and external displacement and refugee status are common results of violence, and UNHCR estimates an overall number of 51.200.000 (UNHCR) including those internally displaced, a high point since WWII, with about half under the age of 18⁽⁶⁶⁾.

In spite of a tendency to treat refugees as homogenous population groups, data and especially qualitative results also indicate that the individual situation and stressors, and even biological factors relevant for treatment might greatly differ⁽⁶⁷⁾. In a global context and for many groups, all steps starting from flight, through survival in often far from safe refugee camps, to return or forced return where feasible, raise multiple challenges. While internal displacement which affects a large part of the populations might not always add transcultural factors, this becomes a key factor in external displacement. The diverse situations encountered and heterogeneous population structures often add to challenges such as asylum procedures, separation from family members who might be in an unclear situation, lost or at risk, cultural differences, or discrimination⁽⁶⁸⁾. The loss of frameworks for individuals or small groups creates a situation different from that of larger populations who might create their own local networks, while role changes especially in second generation refugees lead to new forms of coping or distress^(69,70). Treatment recommendations would require a longer review to address the diverse complex challenges mentioned, but will be shortly summarised.

The mutual culture “shock” between host and refugee culture and transcultural aspects of public health⁽⁷¹⁾, and biological aspects such as cytochromes and competition or interaction between traditional and “western” medicines are additional factors^(72,73) as outlined before. Rehabilitation especially in severe PTSD can be a major challenge as (re-)integration might be inhibited⁽⁷⁴⁾. Cultural idioms of distress not recognised and understood in the host country are part of the communication problems that can be expected to interfere with treatment. In spite of the better public health resources for example in the US, many traumatised victims in need of support and treatment arriving as refugees are therefore not recognised and consequently not sufficiently supported^{(75 (76)}, and the available models might not be effective in cases of severe trauma like torture^(13,77), pain being an adverse predictor^(78,79). A recent comprehensive project has led to similarly critical assessment with a larger refugee population regarding psychopharmacological treatment and Psychotherapy of PTSD⁶⁷, while a review by Palic found a stronger effect of CBT⁽⁸⁰⁾. New and community based approaches are therefore explored through a number of projects. Drosdek has for example reported improvement with a new group treatment approach⁽⁸¹⁾. Community based basic interventions have been demonstrated to be effective by Bolton⁽⁸²⁾, again using the Common Elements Treatment Approach (CETA). Carlsson⁽⁸³⁾ has drawn attention to the special care required if planning interventions with refugee groups.

Children⁽⁷⁴⁾, and especially child soldiers⁽⁸⁴⁻⁸⁷⁾ who require special culture sensitive (re)integration programs but also family systems as a whole^(88,89) have been described as a group of special concern that will be due to the limited frame of this article be only illustrated in an example below. The joint impact on parents and children neutralises needed family support parallel to the lack of local social and medical resources or in case of “unaccompanied minors” loss of even core structures⁽⁸⁸⁾. Economic stress and social isolation are a common aggravating problem encountered in post conflict zones before flight and on return, but also in host countries⁽⁹⁰⁾. Simple, though per se evidence based interventions, can again not address the complexity of rehabilitation and treatment needs^(91,92) and specific intervention packages will be required for special groups^(77,93 94).

In a recent study for UNICEF of children returned to Kosovo after longer stays in European host countries, using a mixed method approach integrating qualitative and quantitative data, we followed both parents and their children after repatriation, and found high rates of untreated PTSD and depression in both parents and children, that lost most network contacts acquired before forced return (“repatriation”)⁽⁹⁰⁾.

Case vignette TnQ: Please turn Case Vignette into a Box.

A 16 year old girl had witnessed the war in an eastern European country. While living conditions were difficult even before the war, as the region and its ethnic groups were discriminated, the village was mostly destroyed by overwhelming military forces. They tried to survive for some time, but intermittent raids, when several family members were killed, forced them to flee the country and ask for asylum in a neighbouring country with her mother and small sister. For some time, the whole family feared that the father, who had been separated from the rest of the family, had been killed, but they could neither mourn nor do anything to help. The family received a temporary permit to stay. When he finally could escape and join the family, he was withdrawn, irritable and fights erupted with his wife at minor occasions. He started to drink alcohol in the evening as he

claimed he needed it to be able to sleep. Her mother consulted a “wise person”, who claimed that her husband behaviour was “bewitched” through a spell of a jealous neighbour and gave her a charm to use, but the problem did not greatly improve. He refused to go to treatment, as “he was not crazy” and also “did not trust doctors here”. The girl felt guilty, as she felt she was responsible to have caused dissatisfaction as she attributed his behaviour to her shortcomings. Feelings of unhappiness and anxiety were partly balanced, when she found new friends in school and a teacher who praised her quick wit and intelligence. Her teacher had also observed her distress, but interpreted it as being due to the new cultural environment. With time, she developed a large group of friends, was invited to their families, and planned for a higher education and felt completely happy in her new home country, with only rare thoughts about her “old” country and the atrocities she had witnessed as a child. After twelve years, in the early morning hours, a group of police with a dog broke into their home, stating that the families permit to stay had been revoked as the war “was over”, and put the family on a plane to the country of origin for “repatriation”.

She had no time to contact her friends. In her town of birth, the girl did not have any friends or relatives. At school, which was hard to reach, she was mocked and could not understand the language properly. Her earlier achievements were useless, and when returning home, her father had started drinking again as memories of the war had become stronger, and there was no work available. The family was shunned, because the other villagers thought they had had “a good time” abroad, being jealous and critical of their “western” behaviour. She became depressed, developed flash-backs of childhood war experiences, thought about suicide, and started seeing a ghost of a friend who had been killed during the war. No Psychotherapy was available, and the next Psychiatrist was in the capital, too far to afford the costs for regular visit. No resolution has been found so far.

Conclusions

Social suffering and mental health problems related to violence as a global public health problem can only be tackled with a holistic approach that takes cultural, social, legal and economic determinants into account, and might also need a strong focus on human rights. Research that can give a reliable assessment of complex long term outcomes is still largely missing, and can be seen as a major and complex challenge for future research.

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